October 17, 2004

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

MDR Tracking #: M2-05-0119-01-SS
IRO #: 5284

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Medical Doctor who is board certified in Neurological Surgery. The reviewer is on the TWCC ADL. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was injured at work on ___. Following the injury he complained of back pain and radicular leg pain into the left leg. He underwent conservative treatments and eventually underwent an IDET procedure on 7-17-2003. There was no relief of the symptomology with the IDET procedure. He was subsequently evaluated by ___ who determined that the patient was suffering from a significant amount of mechanical back pain as well as from a significant amount of radicular nerve root irritation symptomology. It was his opinion that the patient may be a candidate for a decompressive neural foraminal procedure. He ordered an imaging study and a lumbar spine myelogram with post myelogram CT performed on 6-10-2004. The dictated radiologic report on this imaging study reports no evidence of disc herniation, central or foraminal stenosis between T12 and L5. At L5-S1 there was a small 1mm circumferential bulge but no canal or neural foraminal compromise. The patient subsequently had nerve conduction studies on 6-20-2004. This showed evidence of a chronic S1 radicular change but no evidence of active or ongoing denervation. Also reviewed was the ordering surgeon ___'s evaluation of the imaging study which does report that there was some evidence of neural foraminal compromise in the left side at L5-S1.

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of a left L5-S1 partial laminectomy/discectomy.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer's decision is based on the most recent imaging study and lumbar myelogram showing no evidence of central canal or neural foraminal compromise. Also the nerve conduction study results that were performed shortly thereafter showed evidence of a chronic radicular irritation that would be expected from a remote injury but no evidence of acute or ongoing nerve radicular irritation. While there definitely is a discrepancy between the radiologist's report and the recommending surgeon's reading of that myelogram report, at this time taking into account the information reviewed it does not appear warranted to consider a left-sided microdiscectomy.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy. ___ believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 17787, Austin, TX 78744. The fax number is 512-804-4011. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(u)(2).

Sincerely,

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 20th day of October, 2004